

# HARVARD MEDICAL ALUMNI BULLETIN

Spring, 1966

MARCH 14 1966·INTERNSHIP DAY

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# ALUMNI DAY PROGRAM

Friday, May 27, 1966

8:00 a.m.-2:00 p.m.

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## REGISTRATION

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Building A

9:45 a.m.-12:30 p.m.

## MORNING PROGRAM

Countway Plaza

Langdon Parsons '27  
Director of Alumni Relations  
**Welcome**

John Albert Schilling '41, Moderator  
Professor of Surgery, University of Oklahoma

Perry James Culver '41  
Assistant Dean for Admission  
**"Long Shots and Sure Bets"**

Joseph Warren Gardella M. D.  
Associate Dean for Student Affairs  
**"Student Problems and Profiles"**

Howard Hyam Hiatt '48  
Herrman Ludwig Blumgart Professor of Medicine

### **"A Faculty View of the Curriculum"**

Carl Ernest Taylor '41  
Professor and Director of Division of International Health, Johns Hopkins University

### **"The World, The Flesh and the Harvard Man"**

Robert Higgins Ebert M. D.  
Dean of the Faculty of Medicine

Class of 1941 Presentation of Gift to  
Dean Ebert for the Medical School

12:15 p.m.

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## ANNUAL BUSINESS MEETING

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Countway Plaza

12:30 p.m.

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## BUFFET LUNCHEON

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Longwood Quadrangle

2:15 p.m.-4:30 p.m.

## AFTERNOON PROGRAM

Countway Plaza

Round Table Discussion

### **"The Heart Disease, Cancer and Stroke Program"**

Dean Ebert, Moderator

Panelists:

Jerome Pollack  
Associate Dean for Medical Care Planning  
Professor of the Economics of Medical Care

Lamar Soutter '35  
Dean and Professor of Surgery,  
University of Massachusetts School of Medicine

Osler Luther Peterson M. D.  
Visiting Professor of Preventive Medicine, HMS

Claude Emerson Welch '32  
Clinical Professor of Surgery, HMS

John Hilton Knowles M. D.  
General Director of Massachusetts  
General Hospital

Henry Coe Meadow  
Associate Dean for Financial Affairs

3:15 p.m.-4:30 p.m.

General Discussion

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## CLASS REUNION DINNERS

6:00 p.m.

(1916, 1921, 1926, 1931, 1936, 1941, 1946, 1951, 1956, 1961)

# HARVARD MEDICAL ALUMNI BULLETIN

Vol. 40

Spring, 1966

No. 4

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CREDITS: Cover; Cartoons, 15, 16, 17 by Raymond Crane; Photographs:  
M. A. Shahwar, 6-7; Winslow Tompkins, 8-11, 13; Fabian  
Bachrach 19 (Dr. Norman), 28 (Dr. Welch); Bradford F.  
Herzog, Cover, 22, 23.

*The opinions of contributors to the Bulletin do not  
necessarily reflect those of the Editorial Staff.*



# LETTERS

## Sufficiency We Have Efficiency We Need

To the Editor:

I appreciate the nice format used in publishing my article in the Winter issue on "Medical Care Financed by Government in California." Unfortunately, a typographical error crept into the last line of the last sentence of the article.

As printed, it is stated that the "expansion of third party payments may well require increasing consideration by physicians of the organization and *sufficient* delivery of medical care." It should have read "*efficient* delivery of medical care."

With the inefficient duplication, extravagantly inefficient utilization of physician's time and expansive facilities, the unwarranted tonsilectomies, hysterectomies and over utilization of drugs and hospital beds, the *sufficient* delivery of medical care is not the need to be stressed.

As emphasized throughout the article the primary need is better organization and more *efficiency* in the delivery of medical care. It was hoped that the last sentence would leave this need with the reader. But the best laid plans of mice and men go oft astray.

ALLAN M. BUTLER '26  
San Francisco, California

## Something Borrowed Something Blue

To the Editor:

I have read with interest the occasional articles which appear in HMAB concerning the changes in medical education at Harvard. I read with some interest the Christmas issue which detailed the clinical years' changes.

As I have been a little involved in some proposed changes in medical education at the very lowest levels here in Syracuse, I have looked at various experiments in medical education and find

almost monthly increased serumbilirubin levels in my blood.

One of the most disconcerting aspects of all of the experiments in medical education I have found is the sense of something borrowed and something blue that seems to go with every program. There has been an effort to take the best of all systems, the result in structure being, however, something almost subhuman. There seems to be an increased sense of the need for the Universitas rather than the Collegium concept. I fear this strongly tends to decrease the professionalism which has always been of prime essence in medicine.

Perhaps the greatest hopefulness of all

of the systems involved is the apparent acceptance, even though unvoiced, of the fact that medical students come to the schools rather poorly equipped to deal with masses of material. Most of the experiments in education have seemed to boil down to a basic body of medical knowledge and with graphic demonstrations as to its discrimination. But nonetheless, the actuaries of medical science do remain preeminent. Thus, the lip service to the so-called humanities or arts of medicine is even more frightening than if the subject were ignored completely.

RICHARD L. BUTLER '50  
Syracuse, New York

## An Open Letter on Medical Education

To the Editor:

During the last semester the curriculum of Harvard Medical School has been the subject of varied concern. This concern has ranged from simple descriptive evaluation, to constructive criticism of current methods, to rejection of the existing teaching pattern, and reconstruction of what hopefully will be an improved system. My letter is intended as a survey of some current thoughts on medical curricula. It is also the statement of some personal opinions designed to serve as a springboard for future discussion.

Student criticisms of the curriculum have been directed at teaching "mechanisms"—the course, the lecture, the lab, and so on. This is in keeping with the medical principle of diagnosing preferentially the curable disease. Not only do the mechanisms seem most accessible to student action (as events have demonstrated), but, more importantly, the subject of teaching mechanisms is one on which the student has authority to speak. From the standpoint of some fifteen to eighteen years' acquaintance with the genre, the student may appropriately

suggest improvements in these mechanisms. It is clear, however, that the solution of the problems of HMS education (or of medical education in general), lies only partly in the realm of mechanisms. First consider the problem of medical information and its implications for curriculum design.

The exponential increase in medical knowledge demands readjustments in the processing and distribution of information to those concerned. Some comment could be made here on the directions such readjustments might be expected to take.

One measure that has been suggested is to start medical education earlier. Medical or pre-med training would begin at the college level to a markedly greater extent than the present "four science prerequisites." Such a system is presently employed at Johns Hopkins. But the college experience, a valuable educational process in its own right, suffers by this intrusion in time. Improvement in the *level* of the college science course, perhaps in cooperation with the admissions board of a medical school, would seem a happier alternative. Other programs concern themselves with more

efficient use of the period presently allotted to medical schools.

. . . those aspects of science education which must inevitably remain for medical schools must be prepared and presented in a form far more mature and pertinent than that which now prevails. (1)

This brings me to a consideration of problems of curriculum content and design, as ways of dealing with the new knowledge.

Three issues suggest themselves as probable areas of contention in this regard. For convenience I shall term them the problems of proportion, entrenchment and selection.

The problem of proportion refers to those decisions fundamental to curriculum design. What proportion of chronologic time and academic space should be allotted to each medical subject? And, as a corollary, what criteria should determine this allotment? This question, however, is begged by the often-heard statement, "Allotment should be according to the future doctor's needs." This answer, like the present design of the curriculum, fails to take into account that priceless characteristic of the class of future doctors—heterogeneity. As one author expresses the point:

In the literature, medical students have been considered to be a homogeneous group . . . , yet the present findings (of a particular study here described) show many striking contrasts among students. In fact, so polarized are some of the results that it would be hazardous for future studies to talk of "the medical student" without the risk of losing the individual student in too broad a generalization. (2)

Each class consists of individuals with different interests. There are those who enter with their clinical specialty already firmly fixed in mind; those set on basic science but requiring the formality of an M.D. degree; and those with strong leanings one way or the other but with

no definite commitment. Offering such groups a single curriculum designed to serve a "common denominator student," produces the frustrations so often expressed by the members of the student body. The problem is well stated in terms of future fields by a recent study which observes:

To a large extent the schools now offer an all-purpose medical education apparently predicated on the assumption that all its graduates will be all purpose physicians. In fact, their graduates will proceed to careers which differ substantially, among themselves . . . To each of these groups (GP's, specialists, researchers, and medical administrators) the medical school must be prepared to offer a coherent course of study which recognizes from the outset the diversity of goals. (1)

In this respect, Harvard's program has several faults. During the first two years, for example, the student is "exposed," (like some sort of emulsion-coated *tabula rasa*) to all possible aspects of the basic sciences. The theory seems to be that the class as a whole will have at least a verbal acquaintance with all frontiers of any given field. The effect, however, pleases no one. For the clinically oriented, the teaching is too esoteric and irrelevant, "basic for basic's sake." For the basic scientist it is inadequate because of the "sampling" approach and shallow depth of coverage. Moreover, the first year curriculum has been accused by several students of having not a clinical, but an anti-clinical approach, pointing away from any connection and application to medical understanding. Severe lack of continuity with later work thus is produced. The net effect is to leave the student with an expanded vocabulary ("Ah, yes, we had that term, concept, or personage in first year") and a rather shadowy grasp of the investigative frontiers of the subject.

The clinical years are not free from disproportions in terms of need. The third year lecture schedule allocates eight hours to orthopedics and two to psychiatry. This is the case despite the

fact that, while only part of a non-orthopedist's practice has an orthopedic component, there is a psychiatric "overlay" to almost *all* presenting complaints, serious and benign, in all the specialties.

During a lecture, Dr. David Rutstein alluded to clinical disproportions in the following questions: the future basic scientist should indeed be taught some obstetrics, say—but must he be exposed to *all* of obstetrics? The future psychiatrist should be taught biochemistry, say—but must he follow to the bitter end all metabolic pathways known to man?

In sum, the questions to be asked in the realm of proportion concern how much basic science is essential basic science, and how much specialty training is essential specialty training? Answers to these questions must take into account the predicted staggering increase in the volume of subject matter and must redefine what is "essential."

Consideration of the form and nature such revisions brings me to the second area of probable contention; the question of entrenchment, referring both to faculty members and to the status quo.

Clearly, factors other than simply the "future doctor's needs" govern the actual apportionment of instruction time. The teaching of medical students is a prestigious and desirable practice in this medical community. Thus a teacher may wish to have a medical student audience for a certain period of time regardless of whether his topic is appropriate for that period. Again, if a teacher has "always had" a segment of the curriculum for his use, diplomatically it may be difficult to convince him that his time should be shortened. Finally, seniority of teaching personnel or geographic breadth of fame of a lecturer may determine the amount of curriculum time given to a subject.

On the other side of the coin are the involuntary or disinterested teachers. They are required to teach as part of their research program. They emerge, bat-like, from their laboratory caves; blink briefly in the dazzle of the auditorium for the duration of their lecture

*Continued on page 44.*



# EDITORIAL

## “The Thing About Yaws . . .”

**T**ODAY many of us are concerned about man and his dilemma. This century has witnessed a singular display of technical finesse and social awkwardness. We have succeeded in making contact with the moon 240,000 miles away yet we seem unable to communicate with one-quarter of the World population 10,000 miles away. The years of elaborate wars have unfortunately far exceeded the brief periods of peace.

Against this background of what sociologists have euphemistically called “the cultural lag,” the physician does his work. Traditionally and ideally we in the medical and paramedical fields seek the prevention and elimination of disease and the prolongation and betterment of life. It was Ernest Hemmingway who said, “The thing about yaws is to cure them.” So also for us physicians, the thing about pain and pestilence is to do away with them.

In its broadest fulfillment, our role is a dual one: As scientists, we gather data and subsequently share this knowledge with both the medical and non-medical community in order to promote rational discussion and proper decisions. As clinicians, we treat individual patients at home and in the hospital. These are surroundings familiar to us and here society sanctions and urges our presence. But the significance of our efforts at the patient’s bedside dwindles with the realization that a thermonuclear war would create more morbidity and mortality in minutes than physicians have overcome through centuries of doctor-patient relationships.

Unfortunately, we are often myopic when major non-medical problems confront the world. It is difficult for us to wrench ourselves free of the soporific security that comes with the routine of the laboratory, the office, or the wards. As scientists and clinicians, we have dinned the public with facts and warnings about the consequences of such things as high cholesterol diet, lack of exercise, and cigarette smoking.

But a war is being waged and we are threatened by an even larger conflict or at least a longer war. In war, the traditional role of the physician has been to patch up the wounded so that they may enter the fray once again. We have been dutiful *fonctionnaires*—and what we have done, has been done well as the record of war time medical service can tell.

As any war progresses, the physician is soon drawn into certain activities that require him to think not only medically, but also nationally. His medical role may soon become subordinate to his country’s political purposes. Unfortunately, this situation is not a novel one; it happened we know 30 years ago. Commenting upon the Nazi medical experience, an editorial in the *Journal of the American Medical Association* stated, “Perhaps most serious of all was the failure of German medical organizations and societies to express in any manner their disapproval of widely known experiments. Physicians have a right to expect that men trained in the traditions of medicine

would refuse to participate in any way in such acts of inhumanity and these experiments were conducted under the highest authority of the German State. That cannot possibly be considered in the slightest an extenuation of the failure of these physicians to act in accordance with the principles and traditions of their profession.”

From the Nuremberg Proceedings came a code of principles adopted by the World Medical Association in 1948. Two of the provisions were as follows: “I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.”

“I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.”

For the physician in 1966 the problems created by war have a new dimension. With chemical and biological weaponry and the sadistic refinements of psychological warfare, the doctor is no longer, even initially, on the sidelines. Whether in the field or in his laboratory, he is a combatant. Without the help and consent of the medical community, a country would have great difficulty in developing capabilities in these areas. Despite the engagement of our nation in the use of gas, herbicides, and, as recently reported, torture, the medical profession has shown remarkably little concern—a disappointing contrast to their noisy, enraged, and organized protest against another government activity—Medicare.

It is evident that medicine has advanced in an awesome fashion since its first stumblings. These gains have been won at too great a cost for us to end up as purveyors of pestilence and inflictors of pain. To prevent this from happening, each of us must extend his ethical commitment and be alert to the erosion of our values under the guise of expediency. To this task of enlarging our social responsibility, we bring certain advantages:

We possess important information.

We are generally respected by the community and if we present an opinion based on careful data, we will be listened to.

Because disease is universal, there exists a fellowship among physicians; we have the potential to cross frontiers, to communicate with colleagues in all countries including those which diplomats regard as inaccessible. We should be able to work with these doctors in persuading their governments to relinquish activities considered inhumane. Like all mortals, we must fight against our feelings of detachment and moral fatigue.

There is no alternative at this stage of evolution except to try. Only by trying can we hope to tease forth actions that will avoid our extinction—that will avoid undoing the accomplishments of thousands of years of civilization in a second of miscalculation. Like Sisyphus, the physician is used to toilsome tasks. Abraham Flexner, at the conclusion of his autobiography, recalled the bookplate that belonged to the historian Thomas Carlyle. It is as appropriate to our time as it was to his. The bookplate showed a lighted candle and beneath were the words, “I burn so that I may be of use.”

Robert M. Goldwyn '56

This Editorial is based upon a talk given to the Harvard Medical Society, HMS, on March 8, 1966.





*Life is not worth the trouble; the whole sky  
With all its pomp and pageantry of stars,  
Was never worth the heaving of a sigh;  
A tear indeed were paying far too high.*

*Yea! even all this goodly realm of Fars,  
With Shiraz as the jewel in its crown,  
Would find no merchant fool enough to buy  
If Shiraz were not the Beloved's town.*





Gateway to Shiraz

# The Return of the Native

**A** TWELVE YEAR OLD BOY was brought from a distant village by his aging father over barren mountains and dry plains to the Surgical Service of Saadi Hospital of Shiraz in South Iran. He was the fourth patient that year who had been bitten by a snake, and had developed gangrene of the extremity because of the overzealous application of a tourniquet.

Nothing short of an amputation could be done, and this decision was gently conveyed to the solicitous father. The old villager, however, would not have it. He was placing great faith in the whiteness of the dead tibia, ignoring the blackness of the dead soft tissues. No amount of reasoning would dissuade him and, in desperation, I threatened to send the gendarméri (rural police) to his village to arrest the medicine man who had applied the tourniquet. My bluff carried and half an hour later the leg was taken off.

Thus began part of my introduction to the pathology, psychology and medical problems of the rural population of my native country, Iran.

Basically there is nothing new in a native son returning home filled with new ideas to face the old ways of his tribe. After many years of study abroad, the modern foreign student goes through a series of reconditioning experiences which may or may not enable him to find a suitable adaptation to the realities of the situation at home.

by Farrokh Saidi '54





“... and the Achaemenian Kings of twenty-five centuries ago . . .”

What are some of these experiences and how does the native son adapt to the old tribal ways? Will he stick to his newly found principles, or will he modify his acquired foreign views and bow to domestic pressures? Will his education overseas have been in vain, or will he effect significant changes to the old system?

When I left the United States in 1960, I was too preoccupied with the future to reminisce about the preceeding fifteen years I had spent in the New World. I graduated from Harvard Medical School in 1951 and my year of medical internship at Duke Hospital was like wading on the shores of the majestic but limitless ocean of internal medicine. I spent five and a half really magnificent years in surgery at the Massachusetts General Hospital. Above all, I had fully experienced the academic, intellectual and

social life of that uniquely American institution—the teaching hospital. Just for good measure I collected a couple of speciality boards and then I set sail for the “cradle of civilization”—Persia, modern Iran, my native country. On the way home, however, it seemed to be a good idea to spend some additional time in chest surgery in England. But finally, one year later, I arrived in the capital city of Tehran.

The changes in Iran were all too apparent to me. Gone were the two horse droschke's, now replaced by double-decker London buses. A mushrooming of apartment houses had covered every square yard of previously unclaimed desert land in the outskirts of Tehran. But even the choking number of wildly driven automobiles had not out-trafficked the donkey hawkers. One clearly felt the ever increasing contrast between

what was once the old and romantic Persia with what is now the modern, impersonal Iran.

I was immediately thrown into a merry round of visits and countervisits. All the while, I was being carefully scrutinized by the old folk to discover whether I had become “Yankeeized.” Apparently I passed the test, for soon I was taken aside and lectured on the ways and means of getting ahead in Iran. The lessons, though shocking, were simple: never believe higherups; do not hesitate to compromise; and put your interest above that of the group.

Armed with this important knowledge, I left Tehran and journeyed to the city of Shiraz, in the Province of Fars, South Iran. Shiraz is the fairest and most poetical of all cities in Iran. After traveling over endless stretches of barren hills and plains, and through narrow



mountain passes, one goes under an ancient city gate and is suddenly overlooking the picturesque, Shangri-La like city of Shiraz. It lies in the folds of barren mountains, on the edge of a vast green plain, and sparkles with gardens full of tall cyprus trees. It has paved avenues, wide and clean, at least two, blue-domed, mosaic mosques, and a typically oriental bazaar. On the surface, life flows gently in Shiraz and nothing is taken seriously.

The city has many historical claims. A few kilometers north lie the ruins of old Pazargade and Persepolis, the seats of Cyrus and Darius the Great, and the Achaemenian Kings of twenty-five centuries ago. Their dynasty gave Iran an illustrious civilization lasting nearly three hundred years, which was ultimately destroyed by Alexander the Great. Saadi and Hafez, the twelfth and fourteenth century lyric poets were born and died in Shiraz. Their monumental works have guided Iranian thought and have set the literary standard for the Persian language of today.

By previous arrangement with the Iran Foundation, Inc. of New York, I started to work on a so-called full-time basis at the Nemazee Hospital of Shiraz. The Hospital was conceived by a wealthy Shirazi business man, and a great deal of care and effort on the part of men like the late Allen O. Whipple went into the creation of this well equipped two-hundred bed hospital. The government of Iran had generously provided operating funds. Western trained Iranian doctors were to work here under American chiefs until, in due time, they could take over the various departments.

I considered this to be the perfect milieu for my work. It was away from the busy political and bureaucratic life of overcrowded Tehran, allowing me to bury myself in surgical activities, while tackling textbook pathology which had long since disappeared from the American clinical scene. It was an additional pleasure to teach the eager medical students from nearby Shiraz University Medical School.

But, it did not occur to me at first to ask why some twenty-odd well trained Iranian doctors had come and gone before my time. It was difficult to believe that none of them had been "well motivated." The hospital seemed to be

perennially in debt despite generous government subsidies. But when I inquired why lavish dinner parties were given, it was explained to me that the hospital had to keep up a respectable appearance if it was to maintain its high standards of medical practice. The institution, in order to meet its goals, had to remain unique in Iran.

Because money was short, the number of indigent patients had to be curtailed. I was surprised and alarmed one day to read in the newspapers that we were advertising our superior checkup services at Nemazee Hospital to the rich Tehrani population. They could come to us for a fixed price which also included a round trip plane ticket. My indignant objections were overruled. Because the hospital was in serious financial straits, its former appeal for private paying patients had to be restimulated. For the first time, we

seemed to be in competition with European and American private medical centers.

It appeared to me that the hospital's practice of aiming to provide medical care for a selected few was at odds with its well publicized goals of furthering health and education for the country. Both the Iranian and American staff regarded me with suspicion and I soon earned for myself the title of "trouble maker." There was no element of dishonesty or malice in this; but simply a difference of opinion.

It therefore seemed inevitable that I should depart from Nemazee Hospital. But, since my appetite had been whetted for treating the many truly sick, where should I go? The professional life of Tehran is one of ruthless competition for private patients with no holds barred. It held no attraction for me. The concept

"... the seats of Cyrus and Darius the Great ..."





of academic full-time practice could not easily be introduced at Tehran University because of inadequate funds and also because of opposition from some of the clinical faculty. The fact that the official salary of a full-time man was one-tenth of what he could earn on a part-time basis, was a good reason why nobody wanted a full-time position.

**M**EANWHILE, further down the street, beyond the well guarded confines of Nemazee Hospital, another storm was brewing.

Some twenty years ago, a small, provincial University had been established in Shiraz. It was centered around the medical school which had the largest faculty. The man behind this educational venture was an Iranian doctor trained at the American University of Beirut. In due time, he had become dean of the medical school and the chancellor of the University. Among other reforms of far reaching educational impact, he had made English the official language of the school. Basically, however, the educational pattern had remained Persian, which in turn had been patterned on the European continental style. The dean, attending staff, residents and interns would spend a few hours in the mornings in their offices, the wards and operating rooms handling whatever seemed most urgent until about noon. Then everything came to an abrupt halt and everyone would go home for lunch and a siesta. Late in the afternoon, everyone including senior medical students would go to their offices in town to attend to their private practices.

Being a provincial University, Shiraz had another burden to bear; its administrative, financial and curricular control was vested in the vast, bureaucratic machinery of the Ministry of Education centrally located in Tehran. Nevertheless, over the years, the chancellor-dean pursued his progressive plans and with commendable persistence and occasional political maneuvers, he established a closely affiliated community health clinic for the poor. This was the clinical teaching unit of the medical school and in a short span of time, it developed into Saadi Hospital.

When Nemazee Hospital was established as an independent private hospital about ten years ago, it seemed that the

long awaited opportunity for rapid progress of the medical school had arrived. All opposition from the old guard faculty at the University was dismissed by the chancellor-dean. He invited Nemazee Hospital to join forces with him in introducing modern American medicine into the University structure. In his enthusiasm, the dean overestimated the real strength and sincerity of purpose of the avant-garde, and underestimated the power of the traditional opposing forces. A furious battle ensued. Academic skirmishes were fought between faculty members, joined, at times, by the student body who took affairs into their own hands following whomever promised them higher grades and less homework.

The chancellor-dean lost the battle and when the dust finally settled, there was not much left of the University, the medical school or Saadi Hospital. The Nemazee Hospital staff withdrew completely behind their own walls, being under strict orders from the hospital administration not to carry on any teaching at the medical school. Nevertheless, at social parties, sworn enemies drank to each other's health from ruby colored glasses filled with Shirazi wine, while scheming the next day's intrigues.

No one was safe and no words remained secret for long. Within a period of some nine months, half a dozen new chancellors came and went at the University. None were able to remedy the situation.

Underlying these rivalries and hostilities was the younger generation's struggle against the old established ways. The former, however, lacked true strength of conviction and unity of purpose, and defendants of the old system were firmly rooted and backed by much tradition and seniority. A peaceful transition seemed impossible. A commission from Tehran made a cogent assessment of the situation in Shiraz by saying that it was impossible for the old guard to understand fully what the new wanted, and it would be a miracle if they acquiesced to the new ideas.

I was disillusioned, frustrated, and contemplating my next move when suddenly one night, I was called to see a patient at Saadi Hospital. It seems that a tribesman, unaccustomed to the automobile traffic of Shiraz, had been run over by a car. The night before at Saadi Hospital he had had a jejunal perforation sewn up, but was now in shock. I was called to see him in consultation. He was severely distended with clearcut signs of

Saadi Hospital in foreground,





diffuse peritonitis. To my utter disbelief and great dismay, there was not a single nasogastric tube in the entire hospital. Without further thought, I returned to Nemazee Hospital to borrow a levin tube from our large stock. It was too late, however, and the patient died of an anastomotic disruption. The following day I was severely taken to task by the American surgical chief at my hospital who felt himself entrusted with the protection of Nemazee Hospital property and the sole guardian of its medical standards and professional behaviour. He was technically right, of course, in objecting to my having taken the nasogastric tube for an outside patient. But . . .

This was my second rude awakening to the reality of circumstances. This one, however, had its great reward because I found at Saadi Hospital precisely what I had been looking for all along.

**T**HERE was something sad and touching about Saadi Hospital. It served as the only refuge of the many poor and sick of Shiraz and, in fact, for the whole province of Fars—a population of nearly

two million. It was both administratively and physically a neglected two-story structure. Its two hundred beds were constantly filled to overflowing and the equipment and facilities at hand were indeed appalling. There were practically no orthopedic or urological appliances available. The surgical service had only half-a-dozen injection needles and five syringes. The nursing staff, three male nurses and two British sisters, were working furiously to catch up with the hard and unending work. There was little teaching of proper pre- and post-operative care.

Two dedicated Americans, Dr. Robert A. Wise of Portland, Oregon and Kenneth E. Livingston '39 had been there before me. They had devoted enormous amounts of time, energy, and loving care to the improvement of the surgical service with astounding results.

In the face of an unending stream of truly ill patients, the task of giving adequate care and a minimum of bedside teaching for students and house staff was nearly hopeless. To make matters worse, the chancellor then in power could not see the necessity for having a hospital affiliated with the University, and quite arbitrarily reduced the number of hospital beds to fifty. Some of his

other administrative measures showed a similar understanding of the situation; reportedly, when a preclinical science faculty member requested some microscopes for his laboratory, he was told that Galen, Hippocrates and Avicenna were all great physicians, but *they* had not needed microscopes.

The challenge at Saadi Hospital was just too great for me to ignore. Accordingly, I transferred from Nemazee to Saadi Hospital as a full-time surgeon—the first truly full-time man in Shiraz, if not in all Iran.

The resentment against me at Saadi Hospital was quite outspoken. I had to be content with guarded permission to teach and take care of patients. But the receptive and cooperative attitude of the patients, particularly the unsophisticated rural inhabitants who were ready to part with their meager possessions for minimal care, more than offset this resentment and was my most important encouragement at Saadi Hospital. Next to the patients, the medical students provided a badly needed boost to my morale.

With our abundant supply of case material, the serious deficiency of supplies and facilities could be borne with greater magnanimity. I felt I should resign myself to be the intern, resident and attending for general surgery and all the other surgical subspecialties as well, because through my proper example I hoped to induce the hesitant house staff to follow suit. After a few gastrectomies, lobectomies, bypass grafts, esophagectomies followed by uneventful recovery, I was assured of their loyal support. After that, it was easy to establish daily AM and PM ward rounds with everybody in attendance, and to arrange for full coverage at night. We increased the turnover rate of patients by nearly 400 per cent, instituted death conferences, and started a small research laboratory. The enthusiasm of the house staff was contagious and soon we began operating daily, a very heavy schedule, indeed.

We needed an emergency room; we were able to convert a disused storage room into a modest-sized emergency ward. To our great surprise and satisfaction we handled five hundred patients during the first month. This figure rose steadily until by the end of the fourth month, we were seeing an average of two thousand patients a month, and this census has remained at that level ever since. A measure of the public's appreciation was expressed by their willingness to contribute generously for medical

Medical School in background.



care and soon the unit was financially self-sufficient. Nevertheless, a number of Shirazis, particularly from the well-to-do classes, demanded free care, claiming that since the Saadi Hospital was government supported, the government was obligated to provide for their health needs.

It was almost a year before most of the old guard were convinced of my true intentions. The ice soon thawed and I was regularly invited to a cup of hot tea in their offices. As individuals, they presented many more revelations to me than I did to them for despite the many allegations, I found them neither dangerous nor malicious. Some in fact, had remarkable academic and educational feats to their credit. In their early days, when medical practice in Iran was no better than in John Hunter's day in England, they had carried the burdens of their profession honorably for years, away from books, journals and medical meetings. As each of them unfolded their life stories, I felt humbled. Our association led to strong friendships and mutual trust, creating a proper esprit de corps on our surgical ward.

One by one the problems of the surgical service disappeared or were reduced to manageable dimensions. Two more young Iranian surgeons joined our staff. A dedicated Iranian doctor took charge of the administrative side of the hospital. Major physical renovations were carried out; the number of beds gradually rose to over a hundred, and cleanliness, order and efficiency were established under his direction. More nurses were recruited. We were now firmly in business. Nemazee Hospital, meanwhile, had painfully reconsidered its position with relation to the Medical School and had again become a University affiliated teaching hospital.

THE challenge to cope with my own problems had blinded me to a calamity which threatened to wreck the entire University. Students would boycott classes and induce clinical clerks to strike. The administration was deep in bureaucratic chaos. There were rumors that some departments had their ap-

proved budgets transferred to build a swimming pool. A previous chancellor would be handing out faculty rank appointments to some of the more adamant, and usually least qualified individuals, as he was boarding the plane to spend the remaining twenty-five days of the month in Tehran.

Nemazee Hospital, although now deeply in debt, was making the most of the confusion at the University. They arbitrarily were raising staff salaries to keep a crucial number of people, in order to remain academically and medically indispensable to the Medical School. These intense rivalries for power, authority and money kept over-all morale perpetually low while they shook the University to its very foundation.

There was one bright ray of hope on the horizon. The Shah of Iran had invited the University of Pennsylvania to help create a University in Iran based on an American system of higher education. This was a momentous decision on the part of the Monarch with far-reaching educational impact and cultural significance for the country as a whole.

It was decided that the University of Shiraz would be dissolved and a new institution called Pahlavi University be established in its place. With the dynastic name of His Imperial Majesty, this institution was to blaze the trail for Iran's future growth. A delegation from the University of Pennsylvania arrived, surveyed the setting, and produced unique documents outlining an academic basis upon which the projected institution was to be founded. An agreement was reached by the two Institutions providing for the basic ingredients of an outstanding Iranian centre of higher learning. A small team of faculty members from Philadelphia arrived. This was the first of a series of academic links between the two Universities.

There was, however, no basic cadre of competent academic and administrative personnel. The faculty and administration were at odds about all issues regarding organization.

The charter of the University had to be submitted and approved by the Iranian Parliament to give the Institution academic and administrative autonomy. Properly qualified and principled faculty members and administrative staff had to be recruited. Sufficient funds had to be obtained and properly spent. A

proper spirit of mutual trust and cooperation had to be built among the faculty and the student body. And above all, if the University was to remain an Iranian and not an American institution, it had to overcome its indigenous growth problems. Experience at the Nemazee Hospital had shown that complete dependence on American support was neither wise nor practical. First of all a number of Iranians had to make the needed sacrifice for the spontaneous viability of the institution before outside help could be put to effective use. These were all formidable problems.

Many significant changes have taken place during the past year and a half. The University Charter passed through both houses of the Parliament. A new chancellor has been appointed, a man with a broad outlook, proven statesmanship, of unquestioned authority and deeply dedicated to the progress of the University. Some basic administrative and academic changes were effected dissipating the pressures of intrigues. The number of devoted, Western-trained Iranians steadily increased. The Nemazee Hospital underwent a major administrative reshuffle and again became an active teaching hospital of the Medical School. It began to fulfill its initially conceived function of serving the community as an outstanding teaching hospital. Due credit for many of the favorable changes should be given to the members of the Pennsylvania team. Although in their efforts to correct things, they incurred the wrath of certain interest groups and earned the title of "no good do gooders," their straight forwardness and rational tactics carried them forward. They proved once again that principles and fair play would always and everywhere win out in the end, even in Shiraz.

As some difficulties were resolved, new ones presented themselves, exposing fundamental issues at the "desert sand level" of Iranian life. These problems, age old, deeply rooted, inordinately complex, simply will not lend themselves to easy solution. Iran is a country of many mountains but few enthusiastic mountaineers. Perhaps the fatigue of ever seeing forbidding and unrewarding peaks on the horizon has dampened the summit-conquering-spirit of the people. But, mountains are there to be climbed, and, someday soon, with patience and persistence, problems in Iran will be solved.





*The days of distance and the night apart  
Are at an end;  
All the long lonely winter of the heart  
Is at an end.  
No more forever shall the autumn gloom,  
No more forever shall December freeze;  
For lo! The sweet swift-footed April breeze  
Fills all the world with fragrance and with bloom—  
O my own love and friend,  
Our grief is at an end.*



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JUNE 6-24, 1966

AT THE

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Marshall K. Bartlett, M.D.

Thornton Brown, M.D.

John F. Burke, M.D.

Bradford Cannon, M.D.

Benjamin Castleman, M.D.

Oliver Cope, M.D.

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F. Thomas Gephart, M.D.

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To the Editor:

Some time ago I made a review of advances being made in the field of basic sciences. For the benefit of leaders whose contact with the basic sciences is in the all too distant past, a few of the important developments are herewith presented for posterity [and illustrated by Ray Crane].

J. JOSEPH SPEIDEL '63

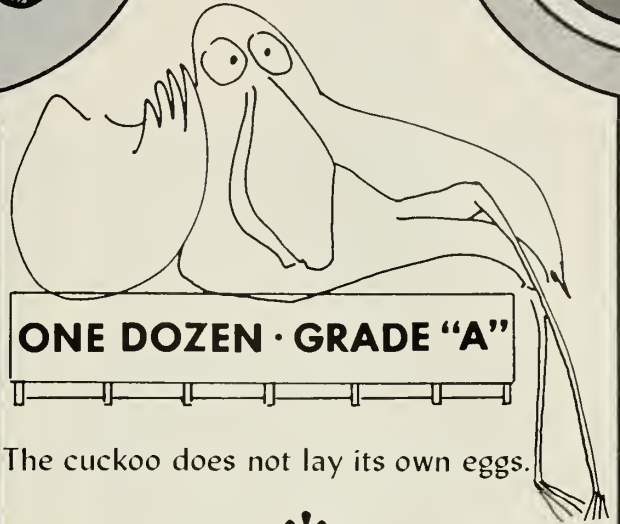
P. S. I wish to thank a large number of Minnesota High School students who made contributions to the study during the course of their general science classes.

# NEW ADVANCES IN SCIENCE ●

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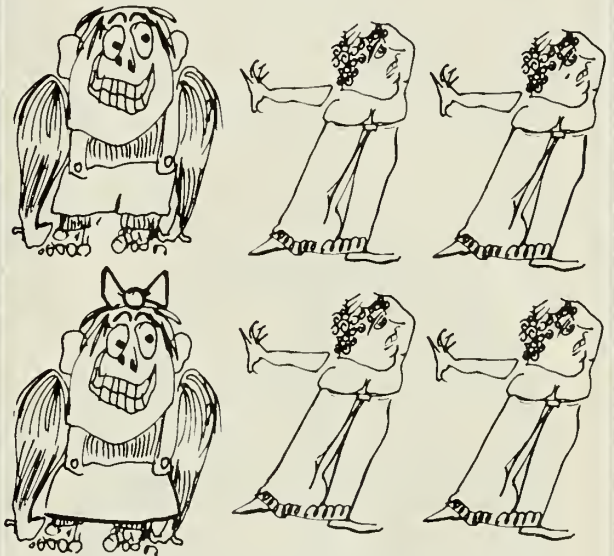
When you haven't got enough iodine in your blood, you get a glacier.



ONE DOZEN · GRADE "A"

The cuckoo does not lay its own eggs.

\*



The theory of evolution was greatly objected to because it made men think.

\*\*\*\*\*

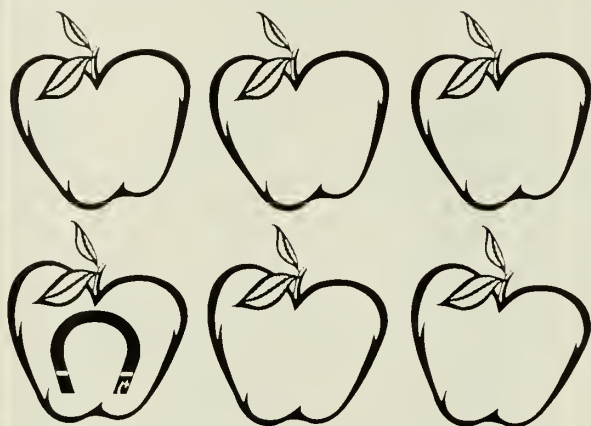
**SMACK! SMACK!  
SMACK! SMACK!  
SMACK! SMACK!**

Sound is a rapid series of osculations.

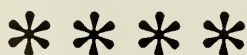




The pistol of a flower is its only protection  
against insects.

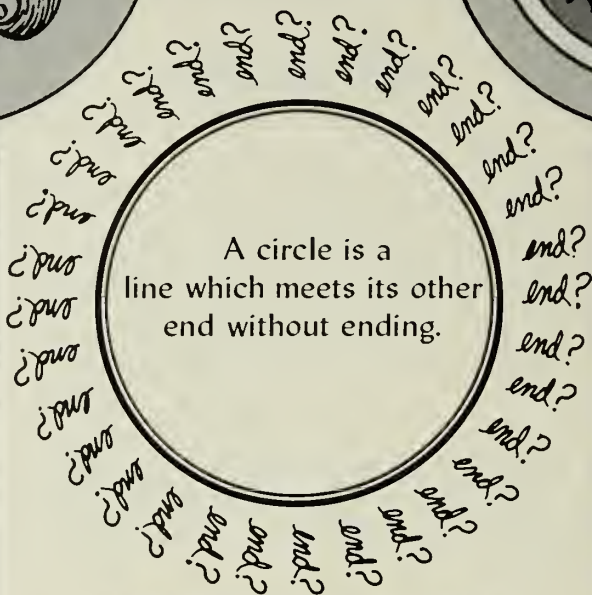


A magnet is something you find  
in a bad apple.



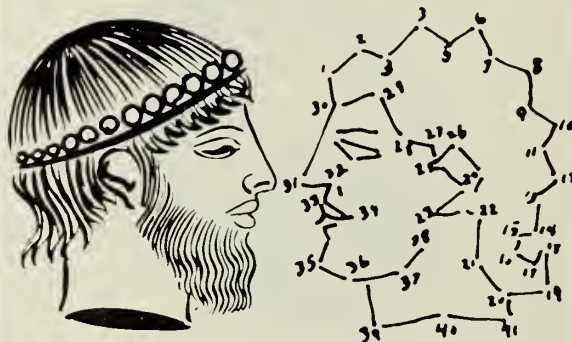
**YEAH!**  
**YEAH!**

If conditions are not favorable, bacteria  
go into a period of adolescence.



The dodo is a bird that is

nearly decent now.



Algebra was the wife of Euclid.







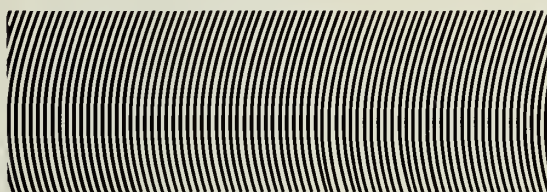
We believe that the reptiles came from the amphibians by spontaneous generation and the study of rocks.

\*\*\*\*\*

2  
UMMM-ER-ER=

Algebraical symbols are used when you do not know what you are talking about.

\*\*



Parallel lines never meet unless you bend one or both of them (Sometimes).



Vegetative propagation is the process by which one individual manufactures another individual by accident.

\*\*\*



The earth makes a resolution every 24 hours.



**FINIS**

## Dr. Silen Comes East to Head BIH Department



*Dr. Silen*

William Silen has been appointed professor of surgery and head of Harvard's department of surgery at the Beth Israel Hospital. He has also been named surgeon-in-chief at the Hospital.

A native of San Francisco, Dr. Silen received the M.D. degree from the University of California Medical School in 1949. After internship and residency at the University of California Hospital, he became assistant chief of surgery at Denver Veterans' Administration Hospital and instructor in surgery at the University of Colorado School of Medicine in 1957. A year later he was promoted to assistant professor in surgery and in 1959, he became chief of surgery at the Hospital.

In 1960 he returned to his alma mater to become assistant professor of surgery and assistant chief of surgery at San Francisco General Hospital. He became chief of surgery in 1961 and associate professor in 1964.

Dr. Silen's research has been concerned with gastrointestinal physiology

and has contributed significantly to the understanding of the pathophysiology of hepatic encephalopathy and hepatic function following porta-caval shunting. He has been especially interested in the relationship between hepatic and pancreatic function and the secretion of hydrochloric acid. With Dr. Ben Eiseman '43A, he was among the first to implicate histamine as the agent responsible for the increase in gastric secretion following porta-caval shunting.

Recently Dr. Silen's investigations have been directed to the metabolic effects of total vagotomy and the advantages of selective vagotomy. These studies have led to important observations on the influence of the vagus on intestinal cell turnover, and consequently, on intestinal mucosal function.

Dr. Silen is certified by the American Board of Surgery and is a member of the Society of University Surgeons, the American College of Surgeons, American Federation for Clinical Research, American Gastroenterological Association, and the Society for Surgery of the Alimentary Tract.

# ALONG THE PERIMETER

## New Associate Dean for Hospital Programs

After July 1, 1966, Dr. Sidney S. Lee will no longer be director of the Beth Israel Hospital. He will, instead, resign from the position he has held since 1959 to become the first Associate Dean for Hospital Programs in the Faculty of Medicine at Harvard.

Dr. Lee, who is nationally known for his efforts in behalf of bettering the social and economic aspects of community health, will assume the challenging job of coordinating the Medical School's activities with work being done in the affiliated teaching hospitals. Dr. Ebert said, "The need for such coordination was strongly recommended by Dr. Robert J. Glaser, now Vice-President for Medical Affairs of Stanford University and Dean of the School of Medicine, during his term in Boston as president of the Affiliated Hospitals Center, Incorporated." Because Boston's community

medical care needs are changing and increasing each year, it is important to develop new relationships between the hospitals and the School. At this time the Faculty of Medicine are formulating plans to facilitate such coordination.

Dr. Lee received his B.S. degree from the Sheffield Scientific School, Yale University, in 1942, the M.D. degree in 1950 and also from Yale, the M.P.H. degree in 1952, and Dr. P.H. degree in 1954. He has been associated with the Beth Israel Hospital since that time. From 1955 to 1960 he was lecturer at the Simmons College School of Social Work, and lecturer on Public Health Practice at the Harvard School of Public Health. Dr. Lee has been lecturer in preventive medicine in the Medical School's Department of Preventive Medicine since 1963 and will retain this appointment.

*Dr. Lee*





## Jacob Fine Becomes Professor Emeritus

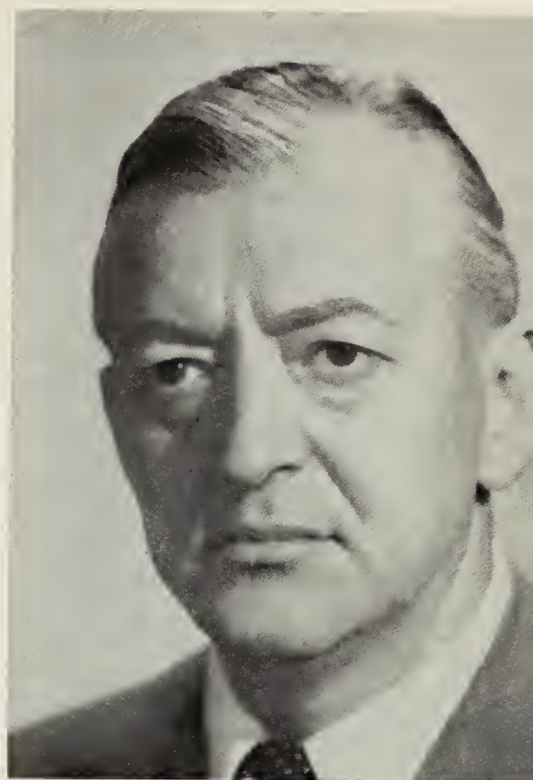
Dr. Jacob Fine '24, Professor of Surgery at the Beth Israel Hospital will become Professor of Surgery Emeritus on July 1, 1966. But as he said: "Why do you need to write about me (in the *Bulletin*)? All my friends know about me already. I am not going to retire from everything, I am only giving up one job that I've had for 18 years. I shall continue with my private practice; I am going to continue surgical research on one of Harvard's Surgical Services; I shall continue doing all the ordinary things I, and others like me, have been doing for years—for instance, in October, I am going to tour Australia for six weeks, as Visiting Surgeon. But there is nothing extraordinary about that . . ."

It is difficult to comply with Dr. Fine's wish that no note be made of an event to come and no passing mention be made of his long relationship with HMS. It began, of course, in 1920 when he first came to HMS as a student, and has been continuous since 1929, when he first joined Beth Israel Hospital as Out-Patient surgeon and assistant in surgery at HMS. In 1937 he became Director of Surgical Research, and, in 1948, Surgeon-in-Chief at the Hospital and Professor of Surgery at HMS. His laboratory investigations in traumatic shock have

led to wider understanding of the methods of treating otherwise irreversible shock in man. Dr. Fine's present objective is to devise a method for achieving sustained coeliac blockade during shock. Recent trials have resulted in the prompt resumption of renal function, increased atrial pressure and cardiac output. There is reason to believe that coeliac blockade may give more superior therapeutic results than those obtained from the use of drugs.

Dr. Fine has assisted in developing an instrument that shows rapid, accurate and repeated measurement of blood volume in patients. The data provided by this instrument can be life saving for those in shock because it determines when there is need for treatment or prevention of shock by transfusion. It can also be used clinically during major surgery, massive hemorrhage and other disorders to provide "on-the-spot" information, otherwise unobtainable, for guiding transfusion therapy.

It is, therefore, with pride that HMAB observes this event because inevitably Dr. Fine's work will continue to be meaningful to many patients and surgeons everywhere. As Howard H. Hiatt '46, Physician-in-Chief at Beth Israel said of Dr. Fine: "As the years pass his



*Dr. Fine*

interests seem to broaden. This, it seems to me, is among the most remarkable aspects of this remarkable man—an ever-deepening curiosity and inexhaustible interest in the new. He has a vigor and kind of intellectual youthfulness that so many of us would be grateful to have even in much smaller measure . . . Medical research and scientific technology have broadened in almost unbelievable fashion in recent years, but so have Dr. Fine's horizons. Isotope techniques, developments in enzyme chemistry, the electron microscope—all are known to him, and exploited in his studies. Thus, as one might predict, the youth, the freshness, the vigor that characterize Dr. Fine, characterize his research as well, and he remains extraordinarily productive."

their careers," said John M. Russell, president of the fund. During the last nineteen years the Foundation has made appropriations of over \$12,800,000 toward support of over 430 Scholars in 88 medical schools. This year 68 candidates were nominated by medical schools, and 25 Scholars were selected by six committees of educators and other professional men.

\*The Markle Foundation was established by the late John Markle, a Pennsylvania coal operator, in 1927 "to promote the advancement and diffusion of knowledge . . ." The Scholars in Academic Medicine program is now the chief interest of the fund.

*Dr. Norman*



## John C. Norman Named Markle Scholar in Academic Medicine

The John & Mary R. Markle Foundation of New York\* has named John C. Norman, Jr. '54, Markle Scholar in Academic Medicine at Harvard Medical School.

Dr. Norman who is instructor in surgery at the Boston City Hospital, will receive \$6,000 a year for the next five years. This sum is to be used to supplement salary, aid research or otherwise assist in the development of the Scholar as a teacher or investigator.

The Markle Foundation has been making Scholar grants annually since 1948 "to relieve the faculty shortage in medical schools by giving support to young teachers and investigators early in

## Karl F. Austen Named to RBBH Post

Karl F. Austen '54, has been appointed associate professor of medicine at the Robert Breck Brigham Hospital. Simultaneously he was appointed physician-in-chief by the Hospital's Trustees.

Dr. Austen was born in Akron, Ohio and received the A.B. degree from Amherst College in 1950. He served his internship and residency on the medical service at Massachusetts General Hospital where he began his clinical research on rheumatoid arthritis, poliomyelitis and chronic pulmonary insufficiency.

From 1956-58, Dr. Austen was chief of rheumatology at Walter Reed Army Hospital where he studied the capacity of salicylates to suppress thyroid function by diminishing the pituitary release of thyrotropic hormone. He was a USPHS postdoctoral fellow at the National Institute for Medical Research in Mill Hill, England during 1959-61. With Drs. John J. Humphrey and Walter Brocklehurst, he studied the mechanism of antigen-induced release of histamine from perfused, sliced, sensitized pig liver. They discovered that the anaphylactic release of histamine in vitro required activation

of a lung esterase which, in turn, could be inactivated by diisopropyl fluorophosphate.

In 1961 Dr. Austen returned to the Massachusetts General Hospital as chief resident in medicine. He has had his own laboratory at the Hospital since 1962, and has continued his studies in antigen-antibody-activated esterase activity. He was the first to demonstrate that the natural substrate of activated component of complement is the second component of complement and that p-toluene sulfonyl L-arginine methyl ester is a suitable synthetic substrate.

The Robert Breck Brigham Hospital was established in 1914 for destitute victims of chronic disease. Today it is the only hospital in the U.S. primarily concerned with the study and treatment of arthritis and related diseases. Throughout its history the Hospital has been closely related to the undergraduate teaching programs of the Medical School. Appointments at the Robert Breck Brigham are made through the department of medicine at the Peter Bent Brigham Hospital.

## Kuwabara Appointed Associate Professor

Toichiro Kuwabara has been named associate professor of pathology in the department of ophthalmology at the Massachusetts Eye and Ear Infirmary.

Born in Matsuyama, Japan, Dr. Kuwabara received the M.D. degree in 1944 and the Doctor of Medical Science degree in 1952 from Kyushu University. In 1952 he joined the staff of the Medical School and the Howe Laboratory of Ophthalmology.

Dr. Kuwabara's research began with a comparison of the natural and experimental deposition of fat in the cornea. He found the two to be distinct entities, contrary to previous conclusions. The experimental condition related to the simultaneous occurrence of atheromatosis in the major arteries.

This observation led him to a study of how the cornea, and eventually many other tissues, reacted to the injection of lipids having different chemical and physical properties. The inference from these lipid studies was that the fat of so-called fatty degeneration arises through a process of active triglyceride synthesis in viable cells, rather than through the unmasking of fat in dead cells as had been

generally believed.

While studying the permutations of lipid metabolism, Dr. Kuwabara noted a remarkable "liberation" of the retinal vessels by appropriate trypsinization of the retina. From this he was able to stain the retinal vessels and their constituent cells in one composite whole and mount them on the flat. Today this technique is used in many laboratories.

Some of the more important consequences resulting from his research are; the discovery of an unusual type of pericyte composing part of the retinal capillary wall, the localization of hypertensive changes to the arterioles, a documentation of the life cycle of microaneurysms, and the formation of shunt vessels in the pathogenesis of diabetic retinopathy.

In recognition of his research achievements, Dr. Kuwabara received the New England Ophthalmological Society Annual Award for the most valuable contribution to ophthalmic research in 1961. In the same year he received the Hektoen Silver Medal Award for a scientific exhibit at the New York meeting of the American Medical Association.

## Pharmacology Award to Jan Koch-Weser

Dr. Ebert announced that the Burroughs Wellcome Fund recently made a \$100,000 Clinical Pharmacology Award to Harvard University. The award will provide support for work to be done by Jan Koch-Weser '54, in developing a comprehensive research and training program in clinical pharmacology at the Massachusetts General Hospital.

Dr. Koch-Weser who is assistant professor of pharmacology at the Medical School and assistant in medicine at the MGH, will receive support for the next five years and will have the additional title of Burroughs Wellcome Scholar in Clinical Pharmacology.

William N. Creasy of New York, president of the Fund said the purpose of the award program is "to assist medical schools in providing laboratories and clinics where students may learn under a first-class scientist and teacher to apply basic scientific knowledge and techniques to the study of clinical pharmacology, and to develop thereby clinical investigators who are capable of evaluating critically the therapeutic efficacy and mechanisms of actions of drugs."

The new training program at MGH will be conducted through Harvard Medical School's department of medicine headed by Dr. Alexander Leaf, Jackson Professor of Clinical Medicine and chief of the Hospital's Medical Service. The scope of the program will encompass human pharmacodynamics, including studies of the absorption, distribution, metabolic fate and excretion in man of both established and new therapeutic agents; the clinical evaluation of the therapeutic effectiveness of pharmacologic agents; and teaching pharmacotherapeutics to medical students during their clinical years at Harvard Medical School.

Dr. Koch-Weser's research has centered on the interaction between the physical and chemical factors which influence the strength of heart contraction, particularly the effect of rate and rhythm of the heart on the strength of its contraction. He has initiated a program at the Hospital to detect, evaluate and record all adverse reactions to drug therapy including correlations between reactions to certain drugs and the age, sex, race and underlying disease of the patients involved.



## Commonwealth Fund Grant to HMS

Harvard Medical School, through the Department of Preventive Medicine, hopes to play a major national role in demonstrating how high-quality medical care can be extended into the community. And, to help plan research and teaching programs in the social aspects of medicine, The Commonwealth Fund of New York has given the Medical School a \$125,000 grant, funds from which will be made available at a rate of \$25,000 annually for the next five years.

Specifically the funds will be used to improve and expand the Department of Preventive Medicine. Dr. Ebert and David D. Rutstein '34, Ridley Watts Professor of Preventive Medicine and Head of the Department, will work together to explore and delineate the problems and issues of medical education and health care.

Dr. Ebert described the Department as one long eminent "in the discipline concerned with the influence of social factors on health and on the occurrence and course of illness, the influence of health and illness on the structure of society, and the use of social resources in maintaining health and in preventing and treating disease."

## INSIDE HMS: Kentucky Elective

On all sides the mountains rose up, criss-crossed by the jagged workings of the coal mines. As the December moon cast its eerie light, I was struck by the solemn power and beauty of the area. Then slowly, as the old bus wound its way deeper into the wooded hills of West Virginia, I began to notice shacks along the road. They were pitifully small, made of rotting wood, with windows broken or boarded. I thought they must be uninhabited but I could see smoke rising from the chimneys and torn white sheets fluttering from clothes lines. This was my introduction to Appalachia, the area to which I had come for a month's clinical clerkship.

I was assigned to the surgical service at the Williamson Appalachian Regional Hospital, one of ten similar institutions set up throughout the Appalachian area by John L. Lewis. It is a 150-bed institution located on the Kentucky-West Vir-

## Dr. Gross Chief of New Cardiac Program

Robert E. Gross '31, William E. Ladd Professor of Child Surgery, has been named chief of a new cardiac program at Children's Hospital Medical Center. He will coordinate the efforts of a team of scientists from the Hospital and the Harvard Medical School to launch an aggressive new attack on heart disease.

Dr. Ebert said, "It is fitting that this program, which has such great potential in helping young heart patients, should be headed by Dr. Gross who already has contributed so much in this field. His new hospital appointment is recognition of the many advances in pediatric cardiac surgery which have come about because of his work . . ."

In 1938, Dr. Gross performed the first successful patent ductus operation to correct a congenital heart defect. For his imagination, courage and skill, he received the Albert J. Lasker Award which cited the procedure as, "An achievement whereby surgery upon the heart and the great vessels was at last removed from the realm of the experimental trial and placed upon a firm clinical basis." More than 5,000 heart operations have been done at Children's Hospital since 1938; all of them under Dr. Gross' guidance and most of them by him.

ginia border. The hospital is staffed by one general surgeon, one anesthesiologist, several nurse anesthetists, four general practitioners, one internist, one obstetrician-gynecologist, one neurosurgeon, one urologist, two pediatricians, one pathologist, one radiologist, and one specialist in physical medicine and rehabilitation. There are no wards, only four-, two- and single-bed rooms. Adjacent to the hospital is an extremely active out-patient clinic and emergency ward which at night is staffed, in rotation, by each doctor in the hospital, including the pathologist and radiologist.

The surgical service is always busy and averages 60 patients per month. The patients are mostly coal miners and their dependents. The panorama of pathology is impressive, as most of the surgical patients have concurrent medical disease. There is a prevalence of chronic lung disease—probably less than 10 per

cent of the adult population over age 40 have normal lungs. For the most part this involves emphysema and chronic bronchitis, although 8-10 per cent of the miners have some form of pneumoconiosis, usually silicosis. The area is low in iodine, and I saw more goiters in my month there than in two previous years in Boston. Genito-urinary tract disease and diabetes mellitus also are common.

The only general surgeon at the hospital is Dr. Paul Walker, a vigorous man of 57 whose work load includes an average of four major procedures a day. His range of surgical capabilities encompasses vascular, general abdominal and thoracic work, and almost all orthopedic procedures. Dr. Walker is assisted by the general practitioners, each of whom take six-month rotations through the surgical service. This arrangement is workable but not fully satisfactory.

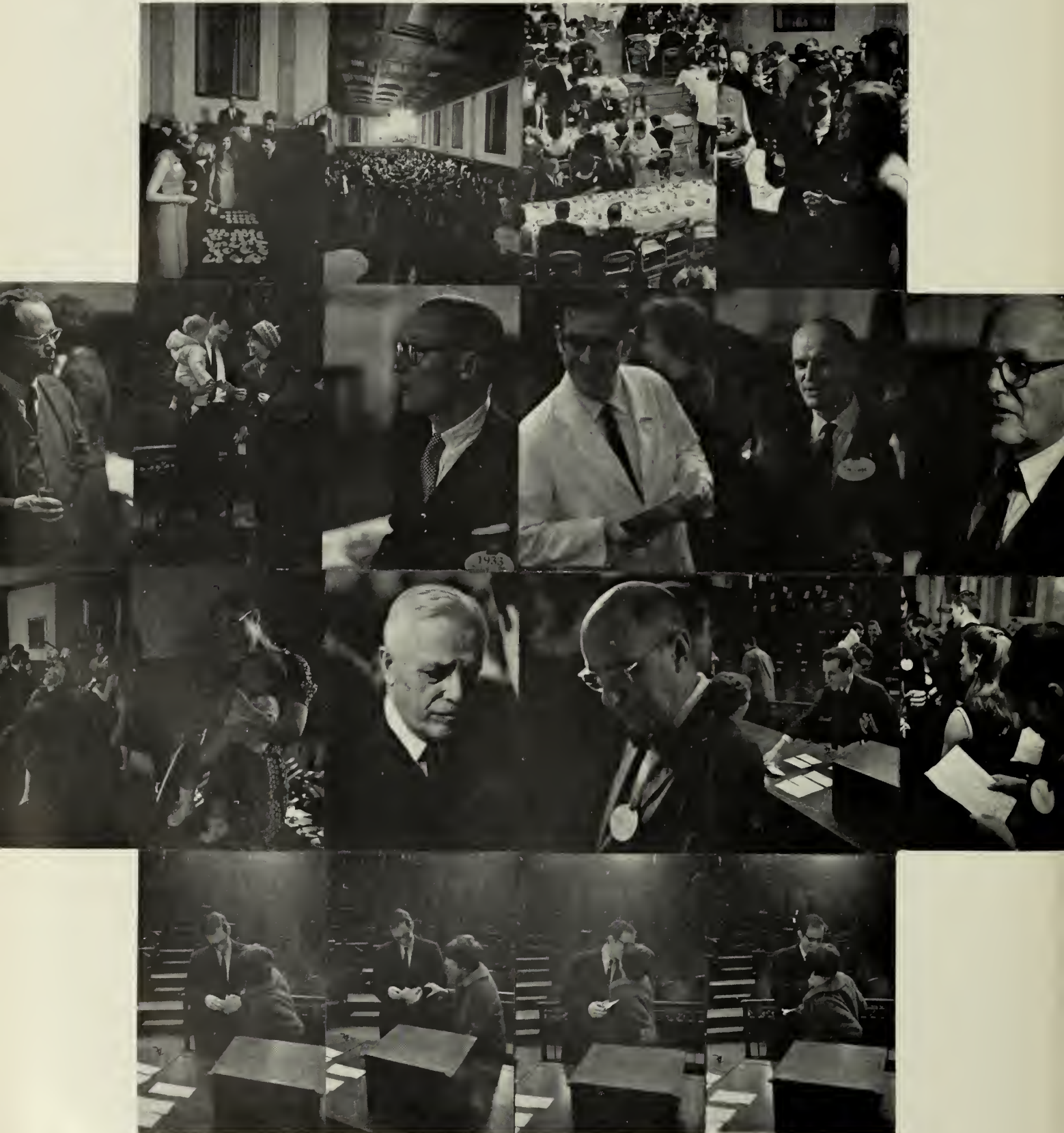
I left Williamson Hospital impressed with the quality of medical care in the area. Although the care is not comparable to that offered by a large university center, it is entirely adequate, extremely available and convenient. There is, however an urgent need for another general surgeon, another internist, and someone with an interest in endocrine problems.

One cannot fail to be impressed by the magnitude of the socio-economic problems in this area. Approximately 30 per cent of the adult male population are unemployed, and there is a vital need for another industry to employ the men left jobless by the inevitable mechanization of the coal mines. At present no such industry is in sight. Yet, I was impressed by the immense vitality of many of these hardy people. Their poverty, unemployment, indolence and despair have been well publicized; much less has been said about their warmth, humor and courage.

I am convinced that visits such as mine are of mutual benefit to both the medical student and the Appalachian region. The area has much to offer us—a patient population manifesting a great deal of pathology, close daily contact with competent men, an exposure to a somewhat different practice than one usually sees in medical school, a chance to assume considerable responsibility, and a first-hand exposure to some of the most pressing socio-economic problems of our time. In return we can offer badly needed extra hands, as well as some fresh ideas. From such mingling, we all will grow wiser.

DENNIS J. BAUMAN '66

After four years,  
“Oh, What a Beautiful Morning”



And in the evening the Alumni Council says,  
“Hello, Doctors”





# INTERNSHIP LIST

Unless otherwise noted all internships start July 1, 1966 for one year.

<i>Name</i>	<i>Hospital and location</i>	<i>Service</i>
Akins, Carlton M.	St. Paul-Ramsey Hospital, St. Paul, Minnesota	Rotating
Alexander, William	Mount Zion Hospital and Medical Center, San Francisco, California	Mixed
Appel, Eugene L.	Presbyterian Hospital, New York, New York	Surgery
Aronow, Abraham	Bellevue Hospital Center (New York University Service), New York, New York	Medicine
Baker, Alan R.	Peter Bent Brigham Hospital, Boston	Surgery
Bauman, Dennis J.	University of Utah Affiliated Hospitals, Salt Lake City, Utah	Mixed
Beck, Laurence H.	Massachusetts General Hospital, Boston	Medicine
Bell, Russell S.	King County Hospital, Seattle, Washington	Rotating
Bergman, David B.	Bronx Municipal Hospital Center, New York, New York	Mixed
Boulter, Philip R.	Boston City Hospital (Harvard Service), Boston	Medicine
Bradley, Jane E.	University of Virginia Hospital, Charlottesville, Virginia	Medicine
Branda, Richard F.	University of Minnesota Hospitals, Minneapolis, Minnesota	Medicine
Breeden, C. Jane	University of California Hospitals, San Francisco, California	Medicine
Brener, Bruce J.	Peter Bent Brigham Hospital, Boston	Surgery
Brown, Stephen M.	Bronx Municipal Hospital Center, New York, New York	Pediatrics
Buchwald, Irwin A.	Bronx Municipal Hospital Center, New York, New York	Medicine

*INTERNSHIP LIST Continued on Page 24*



Bunn, Jack C.	Grady Memorial Hospital, Atlanta, Georgia	Medicine
Carleton, William M.	Beth Israel Hospital, Boston	Medicine
Cassem, Ned H.	Bronx Municipal Hospital Center, New York, New York	Medicine
Catlin, Brian	Boston City Hospital (Harvard Service), Boston	Surgery
Christian, Roger L.	Peter Bent Brigham Hospital, Boston	Surgery
Cihak, Robert J.	Palo Alto-Stanford University Hospital Center, Palo Alto, California	Surgery
Clapp, Roger W.	Mount Sinai Hospital of Cleveland, Cleveland, Ohio	Rotating
Colman, Gerald B.	Medical College of Virginia, Richmond, Virginia	Surgery
Crowell, Robert M.	Massachusetts General Hospital, Boston	Surgery
Cutler, Bruce S.	Massachusetts General Hospital, Boston	Surgery
Dale, David C.	Massachusetts General Hospital, Boston	Medicine
Daniels, Gilbert H.	Massachusetts General Hospital, Boston	Medicine
DeLong, Mablou R.	Boston City Hospital (Harvard Service), Boston	Medicine
Edelson, Richard N.	Presbyterian-St. Luke's Hospital, Chicago, Illinois	Medicine
Falchuk, Kenneth H.	Peter Bent Brigham Hospital, Boston	Medicine
Federico, John V.	Yale-New Haven Medical Center, New Haven, Connecticut	Pediatrics
Finseth, Frederick J.	Massachusetts General Hospital, Boston	Surgery
Fletcher, Robert H.	Stanford University Affiliated Hospitals, Palo Alto, California	Medicine
Fletcher, Suzanne E. W.	Stanford University Affiliated Hospitals, Palo Alto, California	Medicine
Fox, Howard J.	University of Colorado Medical Center, Denver, Colorado	Surgery
Friedman, Joel P.	Peter Bent Brigham Hospital, Boston	Medicine
Galin, Richard S.	University of California Hospital, Los Angeles, California	Medicine
Garren, Ronald B.	Bellevue Hospital Center (Columbia Service), New York, New York	Mixed
Gettelfinger, Thomas C.	King County Hospital, Seattle, Washington	Rotating
Gilmour, David P.	Boston City Hospital (Harvard Service), Boston	Medicine
Ginsberg, Myron D.	Boston City Hospital (Harvard Service), Boston	Medicine
Glass, Jonathan	Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania	Medicine
Glick, Thomas H. B.	Presbyterian Hospital, New York, New York	Medicine
Goetzl, Edward J.	Peter Bent Brigham Hospital, Boston	Medicine
Goldman, Thomas C.	University of Chicago Hospitals and Clinics, Chicago, Illinois	Medicine
Gordon, James H.	Duke Hospital, Durham, North Carolina	Medicine
Gottlieb, Jeffrey A.	Barnes Hospital, St. Louis, Missouri	Medicine
Grave, Gilman D.	Massachusetts General Hospital, Boston	Medicine
Greenes, Robert A.	Graduate study in Computer Science	
Guiney, Timothy E.	Duke Hospital, Durham, North Carolina	Medicine
Gunn, Robert B.	Beth Israel Hospital, Boston	Medicine
Hannah, Richard J.	Vanderbilt University Hospital, Nashville, Tennessee	Medicine
Hardman, George L.	Vanderbilt University Hospital, Nashville, Tennessee	Pediatrics
Harley, Ned R.	Mount Zion Hospital and Medical Center, San Francisco, California	Mixed
Hatem, Charles J.	Boston City Hospital (Harvard Service), Boston	Medicine
Hawkins, Harold B.	Palo Alto-Stanford University Hospital Center, Palo Alto, California	Surgery
Hrehorovich, Victor R.	Bellevue Hospital Center (Cornell Service), New York, New York	Medicine
Hughes, Edward F. X.	Presbyterian Hospital, New York, New York	Surgery
Ilfeld, Frederic W., Jr.	San Francisco General Hospital, San Francisco, California	Rotating
Jacobs, Edward E., Jr.	Massachusetts General Hospital, Boston	Surgery
Jurgeleit, H. Clement	University Hospital, Ann Arbor, Michigan	Surgery
Kaldor, Richard H.	St. Paul-Ramsey Hospital, St. Paul, Minnesota	Rotating
Kaufman, Jay H.	Medical College of Virginia, Richmond, Virginia	Surgery
Kern, Michael L.	Los Angeles County General Hospital, Los Angeles, California	Rotating
Knab, Richard E.	Boston City Hospital (Harvard Service), Boston	Surgery
Koops, Herbert J.	Peter Bent Brigham Hospital, Boston	Surgery
Koran, Lorrin M.	University of California Hospital, Los Angeles, California	Medicine
Krainin, James M.	Jewish Hospital of St. Louis, St. Louis, Missouri	Medicine
Krant, David A.	University of Minnesota Hospitals, Minneapolis, Minnesota	Surgery
Leary, Joan M.	Yale-New Haven Medical Center, New Haven, Connecticut	Pediatrics
Levine, Melvin D.	Children's Hospital Medical Center, Boston	Pediatrics
Levine, Norman S.	Medical College of Virginia, Richmond, Virginia	Surgery
Levisohn, Steven R.	Jewish Hospital of St. Louis, St. Louis, Missouri	Medicine
Loew, Donald E.	University Hospitals of Cleveland, Cleveland, Ohio	Medicine
Ludden, John M.	University Hospital, Seattle, Washington	Medicine
McGillicuddy, John E.	Medical College of Virginia, Richmond, Virginia	Surgery
McInerney, Thomas K.	Cincinnati General Hospital, Cincinnati, Ohio	Pediatrics
McNeil, Barbara J.	Massachusetts General Hospital, Boston	Pediatrics



McNutt, N. Scott	Harvard Medical School, Boston	Anatomy
Marmor, Michael F.	University of California Hospital, Los Angeles, California	Medicine
Mendelsohn, George E.	Boston City Hospital (Harvard Service), Boston	Medicine
Micheli, Lyle J.	University Hospitals of Cleveland, Cleveland, Ohio	Surgery
Mills, John	Boston City Hospital (Harvard Service), Boston	Medicine
Mogielnicki, R. Peter	Massachusetts General Hospital, Boston	Medicine
Mohit, Roberta H.	Georgetown University Hospital, Washington, D.C.	Medicine
Monath, Thomas P. C.	Peter Bent Brigham Hospital, Boston	Medicine
Nasr, Hooshang	Buffalo General Hospital, Buffalo, New York	Medicine
Neisuler, Ross F.	Bellevue Hospital Center (Columbia Service), New York, New York	Mixed
Nelson, Scott H.	King County Hospital, Seattle, Washington	Rotating
Olsen, George D.	University Hospitals of Cleveland, Cleveland, Ohio	Medicine
Oren, Mark E.	Beth Israel Hospital, Boston	Medicine
Owen, Robert L.	Beth Israel Hospital, Boston	Medicine
Payne, Douglas D.	Strong Memorial Hospital, Rochester, New York	Surgery
Pidot, Anne L. R.	Mary Hitchcock Memorial Hospital, Hanover, New Hampshire	Rotating
Pincus, Theodore P.	Massachusetts General Hospital, Boston	Surgery
Pine, Michael B.	Montefiore Hospital and Medical Center, New York, New York	Mixed
Pipkin, Robert D.	Johns Hopkins Hospital, Baltimore, Maryland	Surgery
Pollock, Edward J.	Massachusetts General Hospital, Boston	Medicine
Poole, Thomas A.	Buffalo General Hospital, Buffalo, New York	Medicine
Prager, Elliot D.	Roosevelt Hospital, New York, New York	Mixed
Proskauer, Stephen	DeGoesbriand Memorial Hospital, Burlington, Vermont	Mixed
Ravenscroft, Kent, Jr.	Bronx Municipal Hospital Center, New York, New York	Mixed
Reckler, Jon M.	University Hospitals of Cleveland, Cleveland, Ohio	Surgery
Rie, Michael A.	Presbyterian-St. Luke's Hospital, Chicago, Illinois	Medicine
Roglieri, John L.	Bellevue Hospital Center (Columbia Service), New York, New York	Mixed
Roots, Logan H.	King County Hospital, Seattle, Washington	Rotating
Roth, Loren H.	University Hospitals of Cleveland, Cleveland, Ohio	Medicine
Rothenberg, Richard B.	Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania	Medicine
Rubin, Robert H.	Peter Bent Brigham Hospital, Boston	Medicine
Scharff, David E.	New England Center Hospital, Boston	Medicine
Schoenbaum, Stephen C.	University of Minnesota Hospitals, Minneapolis, Minnesota	Medicine
Scholand, Joseph F.	University Hospitals, Columbus, Ohio	Medicine
Schott, John W.	University of Minnesota Hospitals, Minneapolis, Minnesota	Medicine
Schulman, Joseph D.	Massachusetts General Hospital, Boston	Pediatrics
Shipley, William U.	Massachusetts General Hospital, Boston	Surgery
Shumaker, Jay B.	Jewish Hospital of St. Louis, St. Louis, Missouri	Medicine
Siegel, Robert C.	University of California Hospitals, San Francisco, California	Medicine
Sigman, Robert L.	Boston City Hospital (Harvard Service), Boston	Surgery
Smith, Richard W.	University of Minnesota Hospitals, Minneapolis, Minnesota	Medicine
Sox, Harold C., Jr.	Massachusetts General Hospital, Boston	Medicine
Steinberg, Alfred D.	Bronx Municipal Hospital Center, New York, New York	Medicine
Stevenson, John E.	University of Minnesota Hospitals, Minneapolis, Minnesota	Medicine
Strober, Samuel	Massachusetts General Hospital, Boston	Medicine
Strong, Steven R.	Hennepin County General Hospital, Minneapolis, Minnesota	Rotating
Stubblefield, Phillip G.	University Hospital, Ann Arbor, Michigan	Surgery
Sun, Andrew S. O.	Presbyterian Medical Center, San Francisco, California	Rotating
Sweetland, Ralph C.	Strong Memorial Hospital, Rochester, New York	Surgery
Swett, Chester P., Jr.	Boston City Hospital (Harvard Service), Boston	Surgery
Taylor, Phillip H.	Peter Bent Brigham Hospital, Boston	Surgery
Teichholz, Louis E.	Peter Bent Brigham Hospital, Boston	Medicine
Torop, Paul	Mount Zion Hospital and Medical Center, San Francisco, California	Mixed
Trelstad, Robert L.	Massachusetts General Hospital, Boston	Pathology
Ulyot, Joan W. L.	Beth Israel Hospital, Boston	Pathology
Wegman, David H.	Cleveland Metropolitan General Hospital, Cleveland, Ohio	Medicine
Weiner, Michael S.	Mount Auburn Hospital, Cambridge	Mixed
Weintraub, Bruce D.	Peter Bent Brigham Hospital, Boston	Medicine
Welsh, G. Franklin	United States Air Force (Lackland AFB)	Rotating
Weymuller, Ernest A., Jr.	Vanderbilt University Hospital, Nashville, Tennessee	Surgery
Winig, Paul I.	Medical College of Virginia, Richmond, Virginia	Surgery
Wood, William C.	Massachusetts General Hospital, Boston	Surgery
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CLAUDE EMERSON WELCH '32

Belmont, Massachusetts

A.B. (Doane College) 1927, A.M. (University of Missouri) 1928

- 1932-34 Surgical Intern, Massachusetts General Hospital
- 1935-37 Surgical Resident, M.G.H.
- 1937-48 Assistant to Instructor in Surgery, Harvard Medical School
- 1936-53 Assistant in Surgery to Associate Visiting Surgeon, M.G.H.
- 1942-46 U.S. Army assigned to Sixth General Hospital
- 1948-64 Clinical Associate in Surgery to Clinical Professor of Surgery, H.M.S.
- 1953- Visiting Surgeon, M.G.H.
- 1957-65 Chairman, Tumor Clinic, M.G.H.
- 1963-64 Governor, American College of Surgeons
- 1964- Regent, American College of Surgeons
- 1964- Editor, *Advances in Surgery*

Honorary Fellow: Los Angeles Surgical Society; Detroit Surgical Society; Kansas City Surgical Society; Portland, Oregon, Surgical Society; Central New York Surgical Society; British Columbia Surgical Society; New York Society of Colon and Rectal Surgeons; St. Paul Surgical Society. President: 1966, Boston Surgical Society; 1965-66, Massachusetts Medical Society; 1965-66, Society for Surgery of the Alimentary Tract. Member: New England Surgical Association; New England Cancer Society; American Surgical Association; International Society of Surgery; International Cardiovascular Society; James IV Association of Surgeons; Excelsior Surgical Club; Southern Surgical Association. Alpha Omega Alpha; Boylston Society.

JOHN WISTER MEIGS '40

New Haven, Connecticut

A.B. (Princeton University) 1936

- 1940-1942 Rotating Intern, Pennsylvania Hospital, Philadelphia
- 1942-1943 Resident (Medicine), Massachusetts General Hospital
- 1943-1944 Medical Officer, Pan American Airways (Alaska Division), Seattle, Washington
- 1945-1947 Office of the Surgeon General, U.S. Army  
Chief, Medicine, Army Industrial Hygiene Laboratory
- 1947- Instructor to Assistant Professor to Associate Professor, Yale  
University School of Medicine, Department of Epidemiology and  
Public Health.  
Physician-in-charge Employee Health Service, Yale University
- 1953- Chief of Medical Services, U.S. Steel Corporation, New Haven Works

Member and Chairman, 1962-1963, Connecticut State Medical Society-Section on Preventive Medicine and Public Health; Secretary-Treasurer, 1961-1966, Connecticut Academy of Preventive Medicine; Member: American Board of Preventive Medicine (Occupational Medicine); American Association for the Advancement of Science; American College of Preventive Medicine; American Medical Association; American Industrial Hygiene Association; Connecticut Public Health Association; Industrial Medical Association; New Haven (City) Association; New Haven County Medical Society; Associate Member: American Conference of Governmental Industrial Hygienists; Fellow: American Public Health Association; American Academy of Occupational Medicine. Trustee, Yale Medical Library, 1965-1969; Consultant in Occupational Health to the Surgeon General, U.S. Army, 1947-; Sigma Xi.





WILLIAM RHOADS WADDELL '43B  
 Denver, Colorado  
 B.S. (University of Arizona) 1940

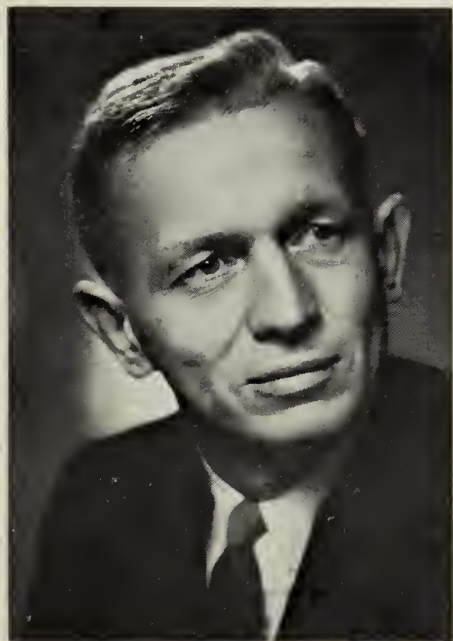
- 1944-1945 Surgical Intern, Massachusetts General Hospital
- 1945-1951 Graduated Residency in Surgery, Massachusetts General Hospital
- 1946 Lt. (j.g.) U.S. Navy, Chelsea Naval Hospital
- 1946-1947 Fellow in Pathology, Department of Legal Medicine, H.M.S.
- 1950 Trainee, National Cancer Institute assigned to Department of Nutrition, Harvard School of Public Health
- 1952-1954 Instructor in Surgery, H.M.S.; Assistant in Surgery, M.G.H.
- 1953-1961 Courtesy and Associate Visiting Staff, Faulkner Hospital
- 1955-1958 Assistant Surgeon, M.G.H.; Consulting Surgeon, Massachusetts Eye and Ear Infirmary
- 1958-1961 Associate Visiting Surgeon, M.G.H.; Assistant Clinical Professor of Surgery, H.M.S.
- 1961- Professor and Chairman, Department of Surgery, University of Colorado Medical School, Denver, Colorado



Diplomate, American Board of Surgery; Member: American Association for Thoracic Surgery; Boston Surgical Society; American Trudeau Society; American Association for the Advancement of Science; American Federation for Clinical Research, Boston Chapter; Board of Thoracic Surgery; New England Surgical Society; American Surgical Association; Rocky Mountain Gastroenterological Society; Society of University Surgeons; Southwestern Surgical Congress; American Gastroenterological Association; Fellow: American College of Surgeons; Member: The Medical Review Club of Denver; Colorado Trudeau Society; Western Surgical Association; Central Surgical Association; Denver Medical Society; Colorado Medical Society; Society of Clinical Surgery; Halsted Society; Denver Clinical Pathological Society; Phi Beta Kappa.

HENRY THEODORE BAHNSON '44  
 Winston-Salem, North Carolina  
 B.S. (Davidson College) 1941

- 1944-1945 Surgical Intern, Johns Hopkins Hospital, Baltimore
- 1945-1946 Lt.(j.g.) MC U.S. Naval Reserve, active duty Philippines
- 1946-1949 Assistant Resident in Surgery, Johns Hopkins Hospital
- 1949-1950 National Research Council Fellow in Basic Science, (Physiology) University of Rochester
- 1950-1951 Instructor in Surgery, Johns Hopkins Hospital  
Resident Surgeon, Johns Hopkins Hospital
- 1951-1956 Markle Scholar in Medical Science
- 1951-1961 Assistant to Associate Professor of Surgery, Johns Hopkins Hospital
- 1961-1962 Professor of Surgery, Johns Hopkins Hospital
- 1963- Professor of Surgery and Chairman of the Department, University of Pittsburgh
- 1952 Diplomate American Board of Surgery
- 1954 Diplomate American Board of Thoracic Surgery



Member and President, 1965, Society of University Surgeons; Secretary, 1960-1965, American Association for Thoracic Surgery; President, 1965-1966, Pennsylvania Association for Thoracic Surgery; Member: American Surgical Association; Southern Surgical Association; Society of Clinical Surgery; American Medical Association; Central Surgical Association; International Surgical Club; Halsted Society; Peripatetic Club; Allegheny County Medical Society; Boylston Society; Lancet Club; Phi Beta Kappa; Alpha Omega Alpha.

GEORGE SHATTUCK RICHARDSON '46  
 Boston, Massachusetts  
 B.A. (Harvard College) 1943

1946-1947 Surgical Intern, Massachusetts General Hospital  
 1947-1948 Research Fellow in Physiology, H.M.S.  
 1948-1950 Lt. to Capt. U.S. Army Medical Corps  
 1950-1953 Assistant Resident in Surgery, M.G.H.  
 1954-1960 Teaching Fellow to Instructor to Clinical Associate in Surgery, H.M.S.  
 1954 Resident, M.G.H.  
 1955-1959 Assistant in Surgery, M.G.H.  
 1957 Certified, American Board of Surgery  
 1960-1964 Assistant Surgeon, M.G.H.  
 1964- Associate Visiting Surgeon, M.G.H.

Member: American Medical Association; Massachusetts Medical Society; Boston Surgical Society; American College of Surgeons; American Association for the Study of Sterility; New York Academy of Sciences; Endocrine Society; Boylston Society; Aesculapian Club.



JOSEPH STOKES III '49  
 La Jolla, California  
 B.A. (Haverford College) 1946

1945-1947 Research Fellow, Department of Physiology, H.M.S.  
 1949-1950 Medical Intern, Johns Hopkins Hospital  
 1950-1951 Assistant Resident in Medicine, Johns Hopkins Hospital  
 1951-1953 Senior Assistant Surgeon, USPHS, Heart Disease Epidemiology Study, National Heart Institute, NIH, Framingham, Massachusetts  
 1953-1954 Resident in Medicine, Massachusetts General Hospital  
 1954-1956 Instructor in Preventive Medicine, H.M.S.  
 1954-1961 Chief, Family Health Program, H.M.S., M.G.H.  
 1955-1961 Assistant in Medicine, M.G.H.  
 1955-1960 Medical Officer, National Heart Institute, NIH, Framingham Heart Program, Framingham  
 1956-1961 Associate in Preventive Medicine, H.M.S.  
 1958-1959 Member, Editorial Board, *New England Journal of Medicine*  
 1959-1961 Associate Editor, *New England Journal of Medicine*  
 1960-1961 Acting Chief, Infectious Disease Unit, M.G.H.  
 1961-1964 Director, Hawaii Cardiovascular Study, Honolulu, Hawaii  
 1962-1964 Director of Medical Education, Queen's Hospital, Honolulu, Hawaii  
 1963-1964 Consultant in Medicine, Tripler Army Hospital, Honolulu, Hawaii  
 1964- Dean and Professor of Medicine, University of California, San Diego School of Medicine



Fellow: American Heart Association Council on Epidemiology and on Clinical Cardiology; American College of Physicians. Board of Directors of American Cancer Society, San Diego County Branch; Advisory Committee on Cardiovascular Diseases, South Pacific Commission; Research Committee, Asian-Pacific Congress of Cardiology; Diplomate, American Board of Internal Medicine; Member: Western Association of Physicians; Western Society for Clinical Research; American Federation for Clinical Research; International Epidemiologic Club; Massachusetts Medical Society.



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